Your HMO Quality Check-up

THCIC

Choosing Well

1999 Texas Medicare HMOs

BROUGHT TO YOU THROUGH A PARTNERSHIP BETWEEN
THE TEXAS HEALTH CARE INFORMATION COUNCIL AND THE TEXAS DEPARTMENT OF HEALTH

About This Report

The Texas Legislature created the Texas Health Care Information Council (THCIC) in 1995 to help Texans get the best possible information for choosing health care. THCIC collects a broad range of data on health care providers and it uses this information to create consumer guides like this one.

This report, presented to you through a partnership between the Texas Health Care Information Council and the Texas Department of Health (TDH), presents objective quality information on Medicare Health Maintenance Organizations (HMOs) operating in Texas during 1998. This information compares Medicare managed care plans and can help you choose a plan that is best for you.

In addition to this guide, the Health Care Financing Administration (HCFA), the American Association of Retired Persons (AARP), and the Texas Department of Insurance (TDI) have developed excellent materials that can help you decide if the Original Medicare Plan or the managed care Medicare plan best suits your health care needs. Information on contacting these groups is listed below.

American Association of Retired Persons
1-800-424-3410
www.aarp.org

Health Care Financing Administration
1-800-633-4227
www.medicare.gov

Texas Department of Insurance
1-800-252-3439
www.tdi.state.tx.us

Table of Contents

More people who qualify for Medicare are choosing a Medicare managed care plan instead of the Original Medicare Plan to provide for their health care needs. With several plans to choose from, how do you know which one to select? There are many factors which go into deciding whether to choose a Medicare managed care plan (Medicare HMO) or the Original Medicare Plan. This guide is designed to provide you with objective, unbiased information to help you decide whether a Medicare HMO is right for you and, if so, which Medicare HMO available might be your best choice.

What is Medicare?

Medicare is a health insurance program for people 65 years of age and older. Some disabled people under 65 years of age and people with permanent kidney failure may also qualify for Medicare assistance. There are two parts to Medicare. Part A (hospital insurance) usually costs nothing and helps pay for hospital care, skilled nursing facilities, hospice care, and some home health care. Part B (medical insurance) costs about $45.50 a month and helps pay for doctors, outpatient hospital care, and some other medical services. While all qualified Medicare participants can get health care through the Original Medicare Plan, you may also have the option to choose a Medicare managed care plan.

The Original Medicare Plan is available everywhere in the United States and is the way most Medicare beneficiaries get their Part A and Part B health care. You can go to any doctor or specialist that accepts Medicare. But some things, like prescription drugs, are not covered. Some recipients purchase Medigap insurance to help cover the costs Medicare does not cover.

The federal government contracts with HMOs to serve some Medicare beneficiaries. Medicare Managed Care Plans are only available in some areas of the country and you can only go to doctors or hospitals

on the plan's list. A listing and map of all Texas counties with Medicare managed care plans (Medicare HMOs) can be found on page 6 of this report. Health maintenance organizations (HMOs) provide a wide range of health services and preventive health care through networks of doctors, hospitals, clinics, pharmacists and other providers. The HMO coordinates the services of its network of providers and monitors the quality of care its members receive.

Managed care plans cover all of Part A and Part B health care. However, members may also pay a small fee (called a co-pay) for health care services such as doctors' visits, emergency care and prescriptions. Members choose a primary care physician (PCP) from doctors who belong to the HMO. The PCP manages the patient's health care including referrals for specialty care, laboratory, x-ray services and hospitalization when needed. Some plans cover prescription drugs so your overall medical expenses might be lower than in the Original Medicare Plan.

You can join a Medicare HMO if:

1) you have both Part A (Hospital Insurance) and Part B (Medical Insurance),
2) you do not have permanent kidney failure with dialysis or a transplant, and
3) you live in the plan's service area.

Individuals with permanent kidney failure can stay in the plan if they already participate in a Medicare HMO. However, individuals enrolled in a Medicare HMO who move out of their service area into an area without a Medicare HMO must switch to the Original Medicare Plan.

Medicare managed care plan participants have certain guaranteed rights which include the right to get emergency care when you need it, a right to choose a woman's health specialist, and the right to appeal denied claims. For a complete listing of all of your rights as a Medicare participant, please refer to your copy of the "Medicare & You 2000" handbook sent to you or call 1-800-MEDICARE.

Quality Information

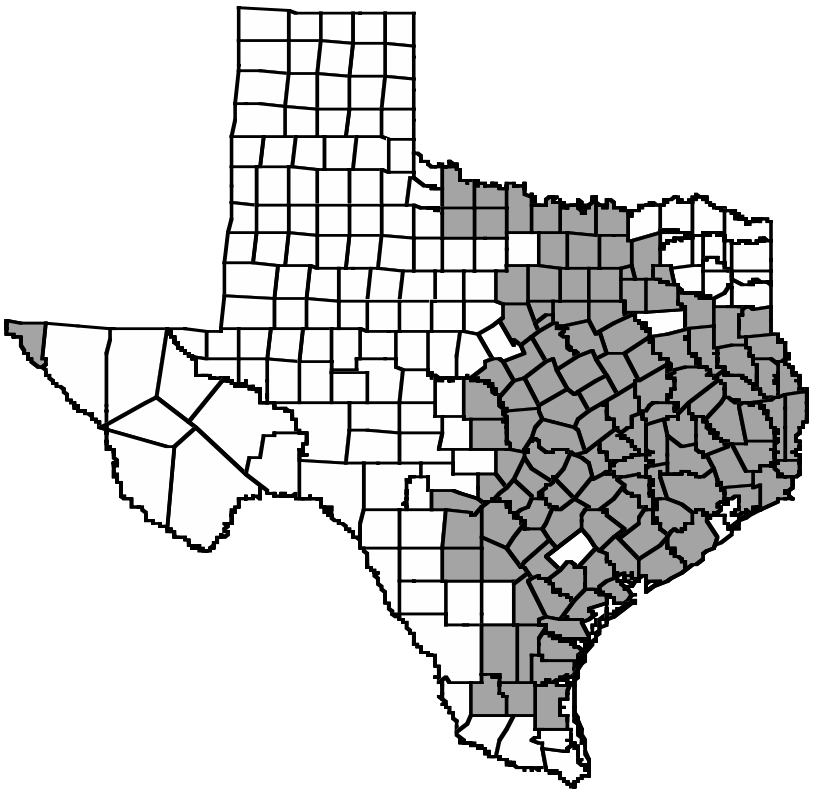
All HMOs operating in Texas are required by State law to provide information about their services and practices within the state to the Texas Health Care Information Council (THCIC). Whether you are choosing a Medicare HMO for the first time or you are evaluating how your current HMO is performing, this guide can help you make an informed choice.

Quality is how well the plan keeps its members healthy or treats them when they are sick. If you are considering a managed care plan as your Medicare option, quality comparisons are provided to help you choose the plan that is best for you. THCIC requires Texas HMOs to use a specific set of objective performance measures to report information about their plan's performance. These measures, called the Health Plan Employer Data and Information Set (HEDIS®), were developed by the National Committee for Quality Assurance (NCQA) as a way for health care consumers to objectively compare HMO performance and ensures that the performance measures used for Texas HMOs are comparable to those used for HMOs nationally.

You can use the information provided in this guide to decide if the health plans that you are interested in have been successful in providing preventive and medical care services to their members.

For this guide, all Medicare health maintenance organization (HMO) operating in Texas during 1998, the most recent data available, are listed alphabetically followed by the name of the area it serves for each HEDIS® performance measure. Some HMOs are not included in this report because they had low membership during 1998 or they were not in business during the year. A listing of the HMOs available as of January 1, 2000 and how to contact them can be found on page 44.

Texas Counties with Medicare HMO Coverage in 1998



Anderson
Angelina
Archer
Atascosa
Austin
Bandera
Bastrop
Baylor
Bee
Bell
Bexar
Blanco
Bosque
Brazoria
Brazos
Brooks
Burleson
Burnet
Caldwell
Calhoun
Chambers
Cherokee
Clay
Collin
Colorado
Comal
Cooke
Coryell
Dallas
Denton
Duval
Ellis
El Paso
Erath
Falls
Fayette
Fort Bend
Freestone
Frio
Goliad
Gonzales
Grayson
Grimes
Guadalupe
Hamilton
Hardin
Harris
Hays
Hill
Hood
Houston
Hunt
Jackson
Jasper
Jefferson
Jim Hogg
Jim Wells
Johnson
Karnes
Kaufman
Kendall
Kenedy
Kleberg
Lampasas
Lavaca
Lee
Leon
Liberty
Limestone
Live Oak
Llano
Madison
Matagorda
McLennan
Medina
Milam
Mills
Montague
Montgomery
Nacogdoches
Navarro
Newton
Nueces
Orange
Palo Pinto
Panola
Parker
Polk
Rains
Refugio
Robertson
Rockwall
Rusk
Sabine
San Augustine
San Jacinto
San Patricio
San Saba
Shelby
Smith
Somervell
Tarrant
Travis
Trinity
Tyler
Van Zandt
Victoria
Walker
Waller
Washington
Wharton
Wichita
Wilbarger
Williamson
Wilson
Wise

Breast Cancer Screening

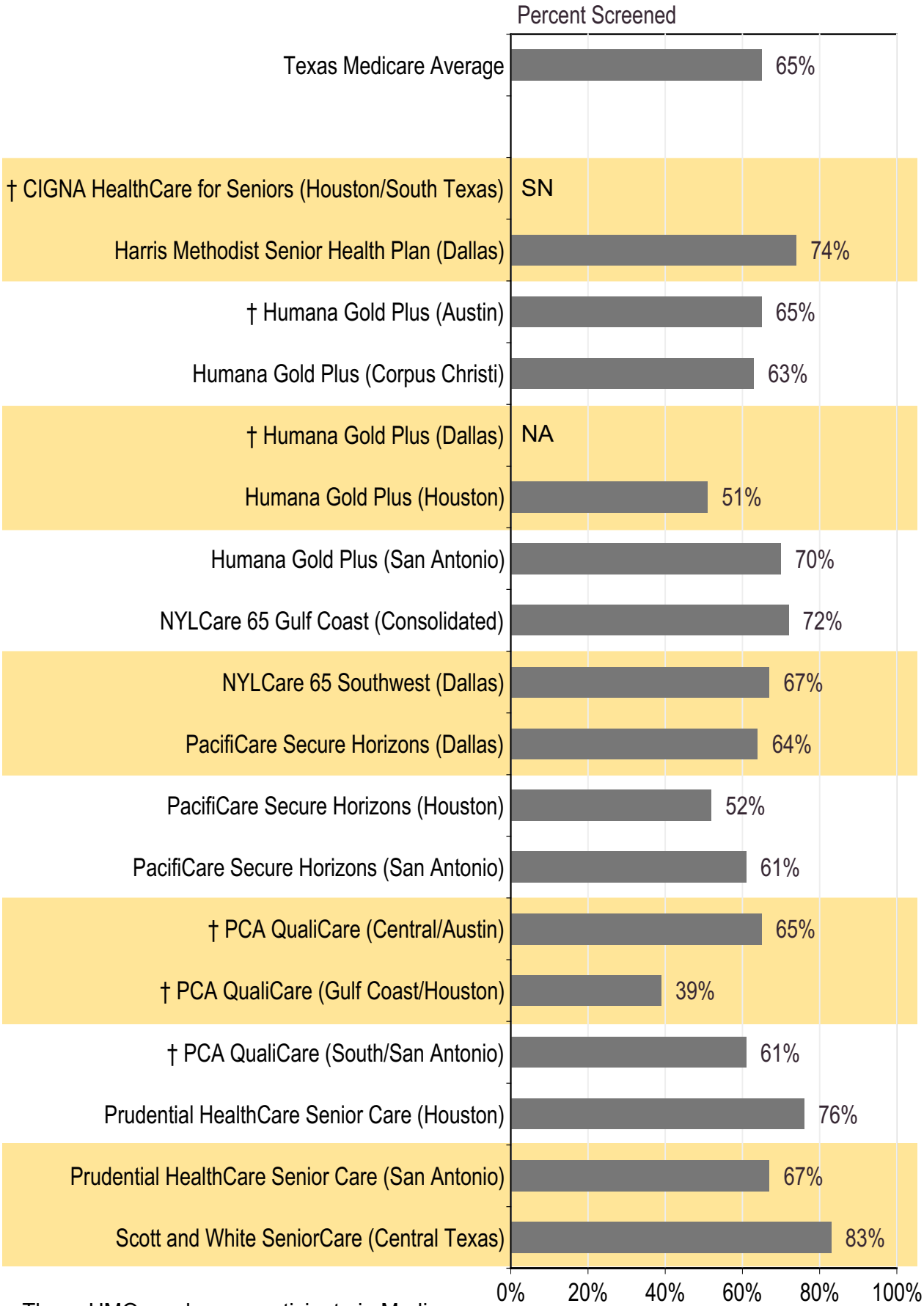
Definition: The percentage of women age 52 through 69 years of age in Medicare who had a mammogram during the past two years.

Breast Cancer is the second most common form of cancer among American women. The American Cancer Society predicts that there will be about 182,800 new cases of breast cancer in the year 2000 and about 40,800 deaths from the disease. The earlier breast cancer is found, the better the chances for successful treatment. One of the best ways to detect breast cancer tumor early is through a mammogram. A mammogram is an x-ray of the breast that identifies tumors which are too small to be detected by self examination. Mammograms have been shown to reduce breast cancer deaths by 20 to 40 percent among women 50 years and older.

The graph on the next page shows the percentage of women age 52 through 69 years old in each Medicare HMO in Texas who had a mammogram during the past two years.

Texas Medicare Average
1997 .....64%
1998 .....65%

Breast Cancer Screening



† These HMOs no longer participate in Medicare.
NA HMOs with fewer than 30 patients for this measure are not reported.
SN Small Number: HMOs that have between 30 and 99 patients for this measure are not reported.

Eye Exams for People with Diabetes

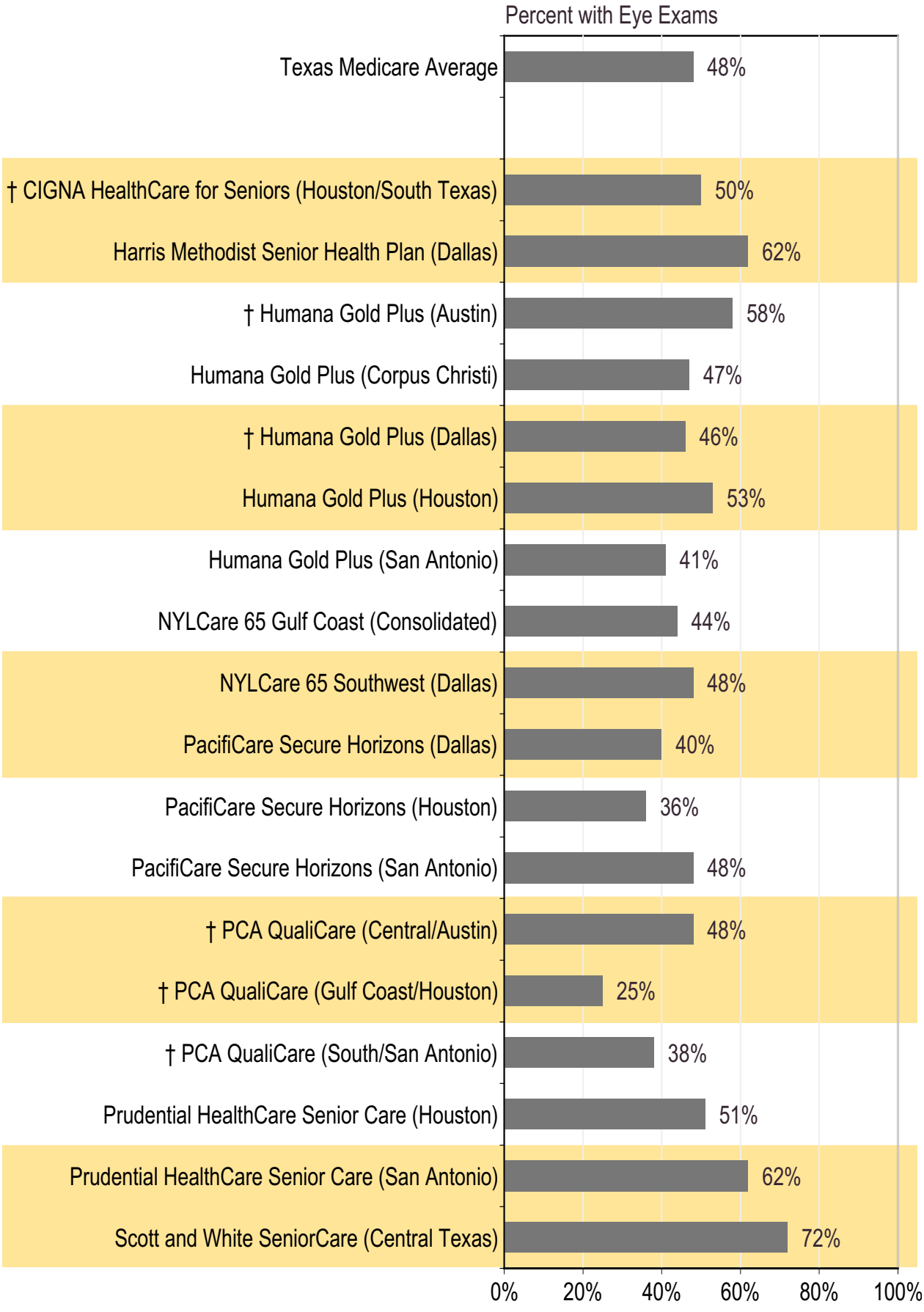
Definition: The percentage of Medicare members with diabetes (Type I and Type II) age 31 and older who had a retinal eye exam during the past year.

According to the American Diabetes Association, almost 16 million Americans have diabetes and over 700,000 new cases are diagnosed every year. Diabetes is the leading cause of new cases of blindness for people 20 through 74 years of age, resulting in an estimated 12,000 to 24,000 diabetics losing their sight each year. Although diabetic retinopathy (diseases of the retina) is a common complication of diabetes, early detection and treatment of eye disease can prevent diabetics from losing their sight. Regular dilated retinal exams are considered the most effective method for early detection.

The graph on the next page shows the percentage of diabetics age 31 years and older in each Medicare HMO in Texas who had a retinal eye exam during the past year.

Texas Medicare Average	
1997	43%
1998	48%

Eye Exams for People with Diabetes



† These HMOs no longer participate in Medicare.

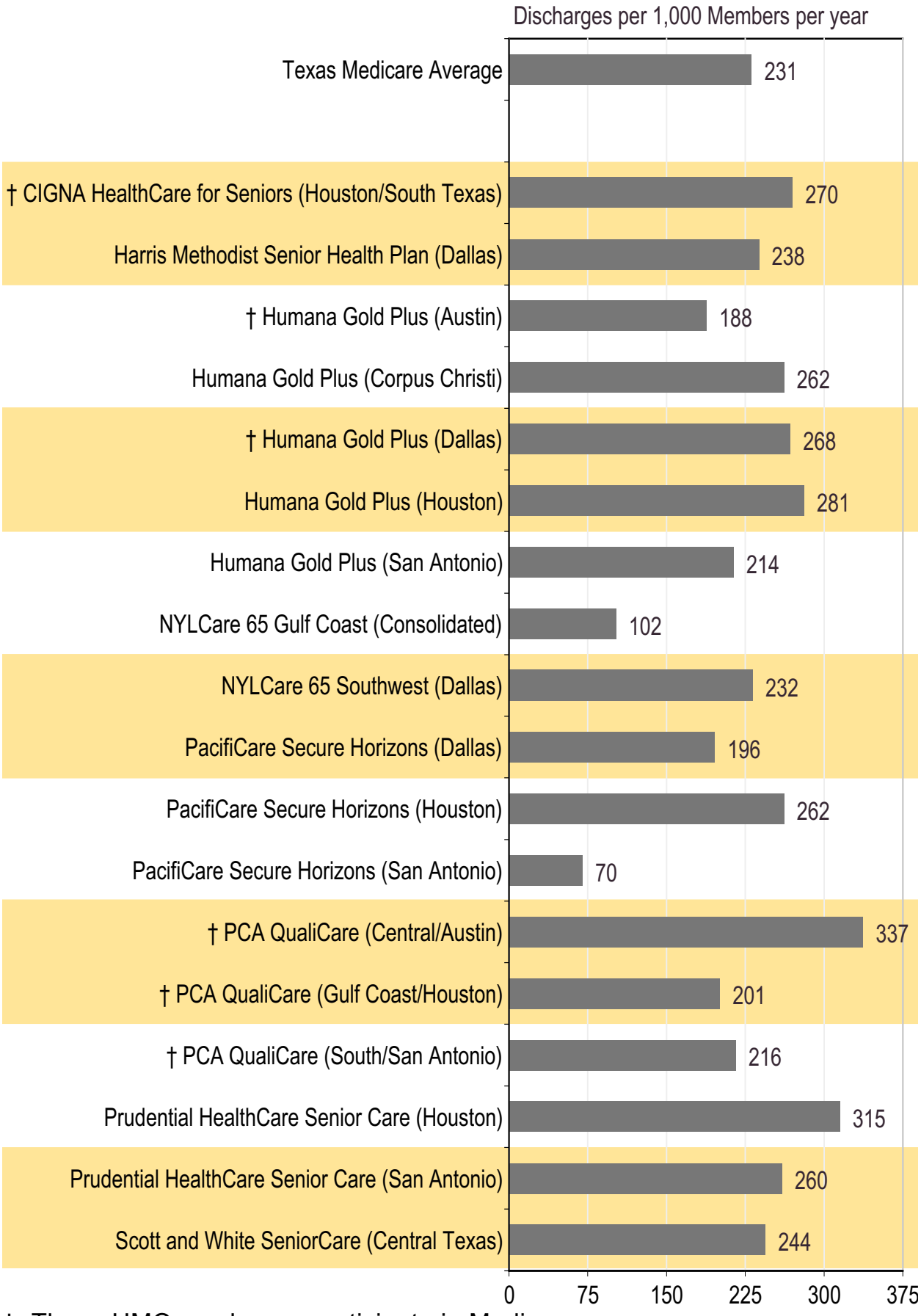
Inpatient Utilization - Total

Definition: The number of total acute inpatient hospitalizations and average length of stay.

Hospitalization remains one of the most expensive costs to health care today whether it is for surgical or non-surgical medical treatments. The inpatient utilization measure can provide information on how an HMO chooses to manage the care it provides for its members. For example, when comparing inpatient utilization with ambulatory care services, differences between the two may indicate whether a plan uses inpatient or outpatient settings more often. Many factors influence rates and lengths of stay for inpatient utilization making the information difficult to interpret. It is best not to use this information as the deciding factor for which health plan you choose, but rather as one part of the picture of how a plan provides treatment to its members.

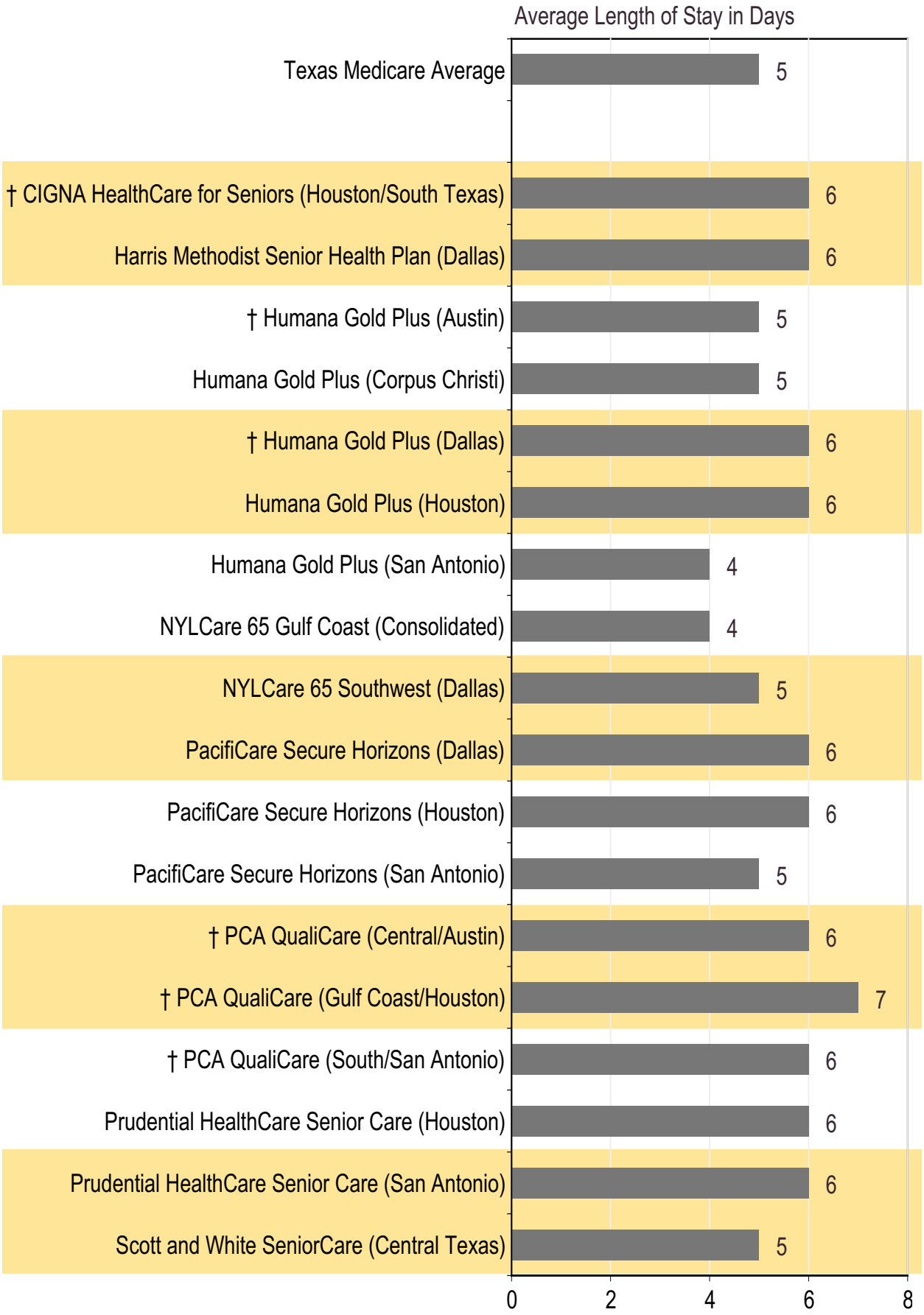
The graphs on the next two pages show the number of hospitalizations per 1,000 members and the average length of a hospital stay for total inpatient utilization in each Medicare HMO.

Inpatient Utilization - Total



† These HMOs no longer participate in Medicare.

Inpatient Utilization - Total



† These HMOs no longer participate in Medicare.

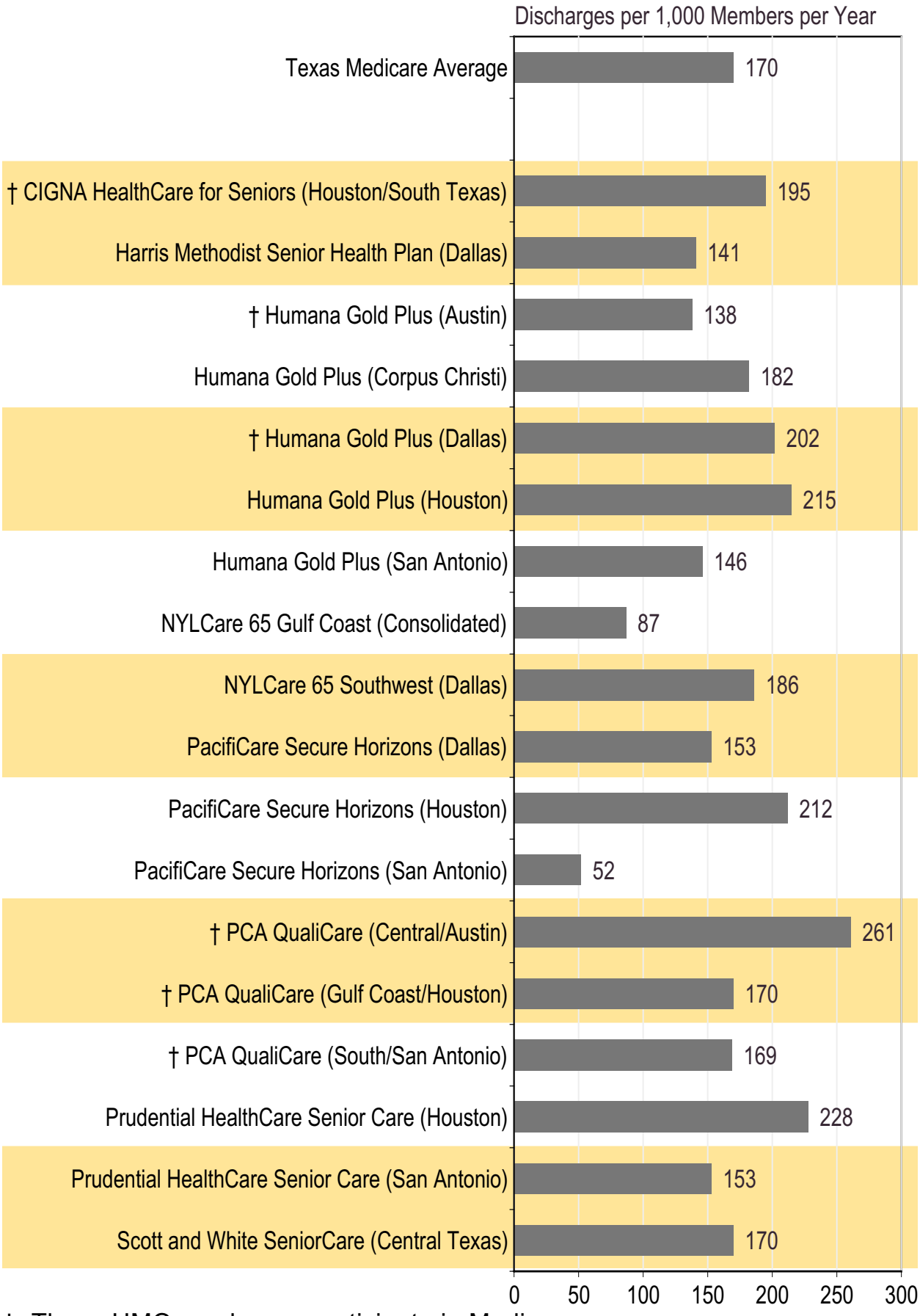
Inpatient Utilization - Medicine

Definition: The number of medicine inpatient hospitalizations and average length of stay.

Medicine - inpatient utilization is non-surgical treatment requiring admission to the hospital, for example, hospitalization for an illness like pneumonia. This measure may indicate the use of hospitalization for treatment compared to treatment done at the doctor's office or on an outpatient basis. Hospitalization for treatment tends to increase the cost for both the plan and the plan member.

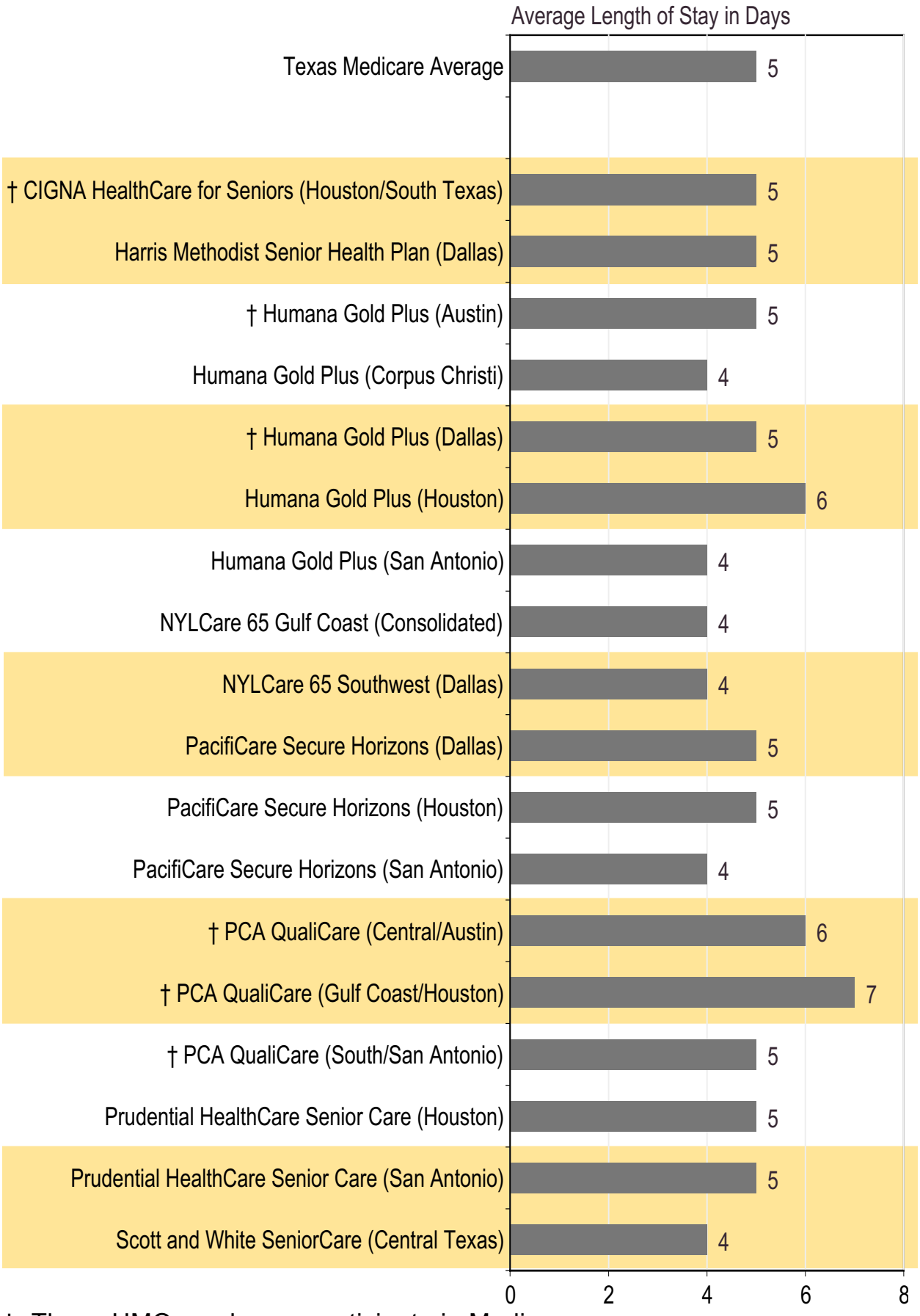
The graphs on the next two pages show the number of hospitalizations per 1,000 members and the average length of a hospital stay for medicine inpatient utilization in each Medicare HMO.

Inpatient Utilization - Medicine



† These HMOs no longer participate in Medicare.

Inpatient Utilization - Medicine



† These HMOs no longer participate in Medicare.

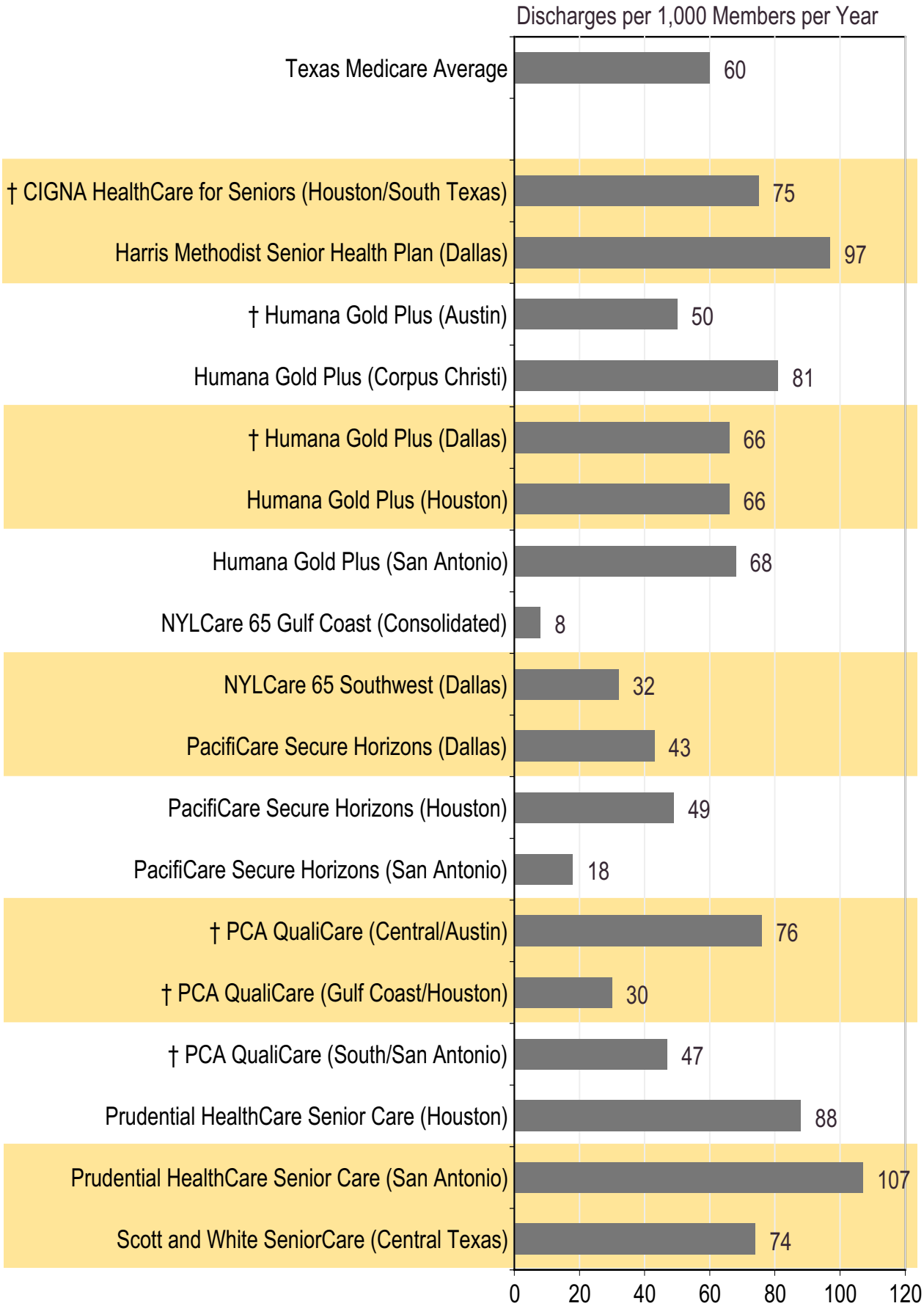
Inpatient Utilization - Surgery

Definition: The number of surgery inpatient hospitalizations and average length of stay.

Inpatient surgeries are performed in a hospital setting and require the patient to spend at least one night in the hospital. These are more expensive than outpatient surgeries. Comparing inpatient surgical use with ambulatory surgeries (outpatient surgeries) gives an idea of how much surgery is performed on an inpatient versus outpatient basis.

The graphs on the next two pages show the number of hospitalizations per 1,000 members and the average length of a hospital stay for surgery inpatient utilization in each Medicare HMO.

Inpatient Utilization - Surgery



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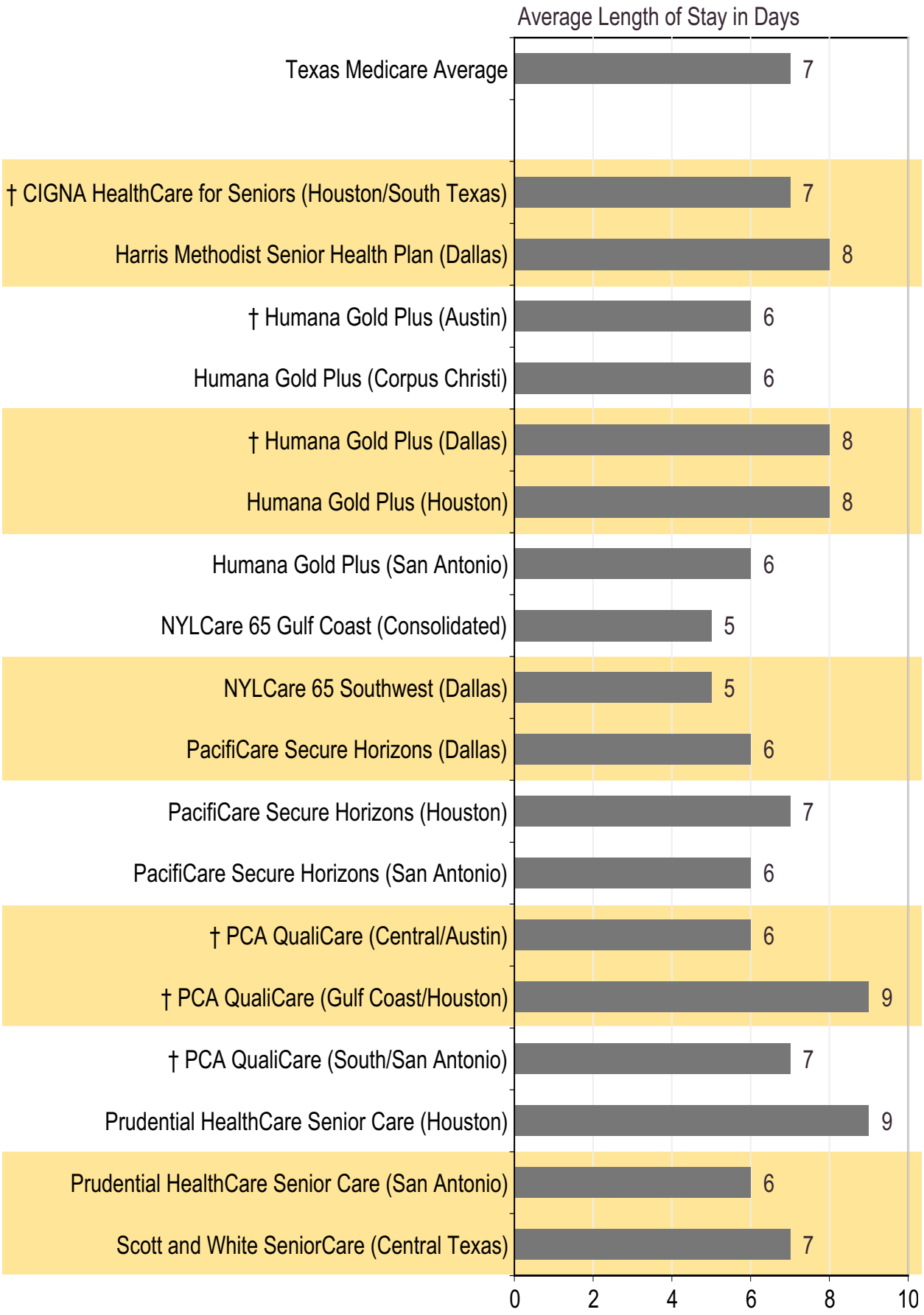
Inpatient Utilization - Surgery



† These HMOs no longer participate in Medicare.

Ambulatory Care

Definition: The number of ambulatory care services per 1,000 members per year.

Ambulatory care is care for people who visit for a specific purpose and do not have to stay in the hospital. Non-inpatient care is less expensive than admitting someone to the hospital. Ambulatory care is grouped into four types of services: outpatient visits, emergency room visits, ambulatory surgery/procedures, and observation room stays.

Outpatient Visits are face-to-face visits between practitioners and patients. Health plans, which promote effective outpatient treatment, may have high numbers of outpatient visits.

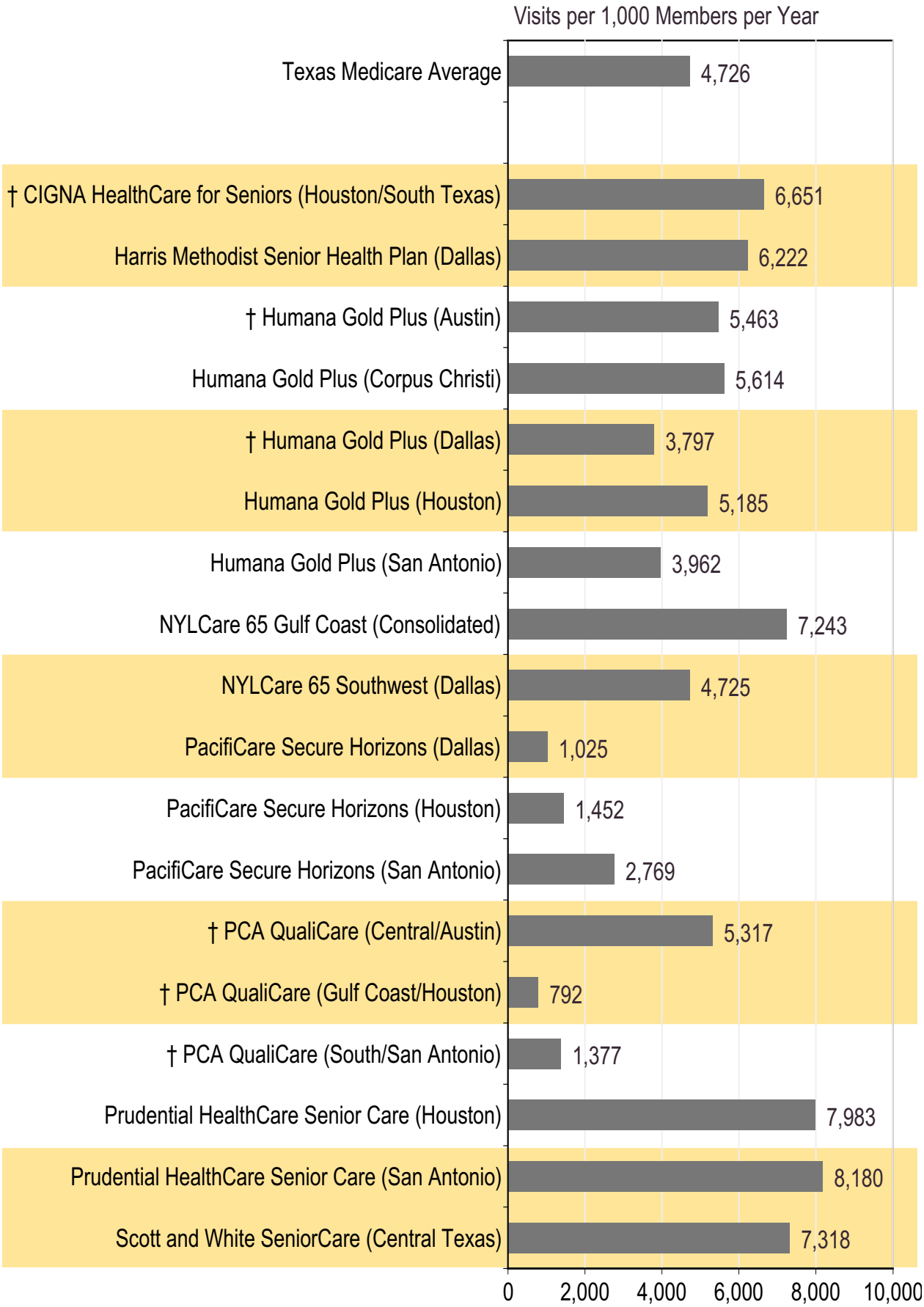
Emergency Room Visits are visits to an emergency room rather than a clinic or physician's office. Although patient behavior is a factor in the decision to use an emergency room rather than a doctor's office, it may be an indicator that the plan does not have enough physicians.

Ambulatory Surgery/Procedures are surgeries or procedures that are performed at a hospital or a surgery center in which the patient leaves by the end of the day. Many procedures which formerly required hospitalization are now routinely performed on an outpatient basis.

Observation Room Stays are stays where the physician determines whether the condition of a patient requires admission to the hospital. The observation room is generally part of the outpatient department of a hospital.

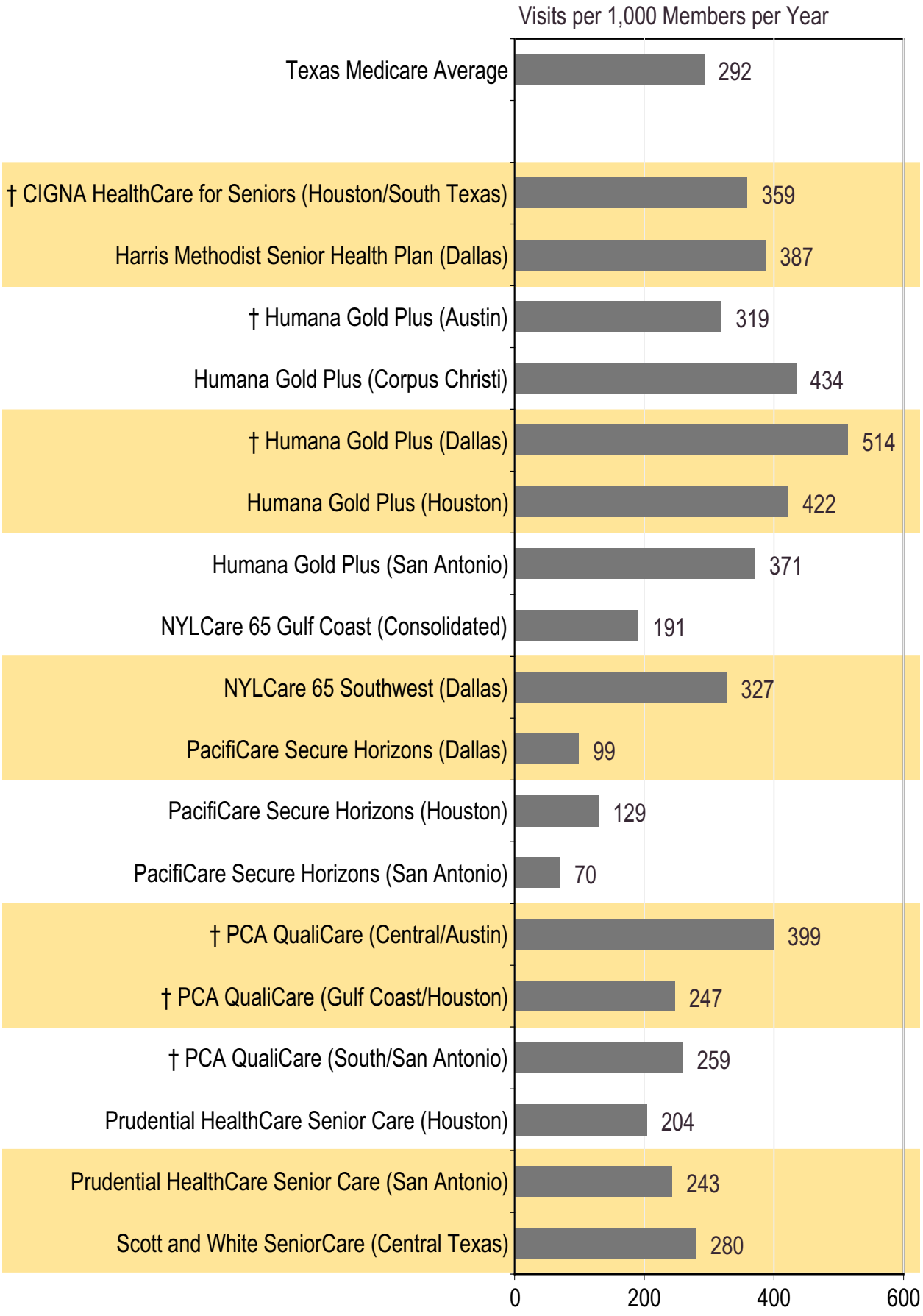
The graphs on the next four pages show the number of ambulatory care visits per 1,000 members for each Medicare HMO.

Ambulatory Care - Outpatient Visits



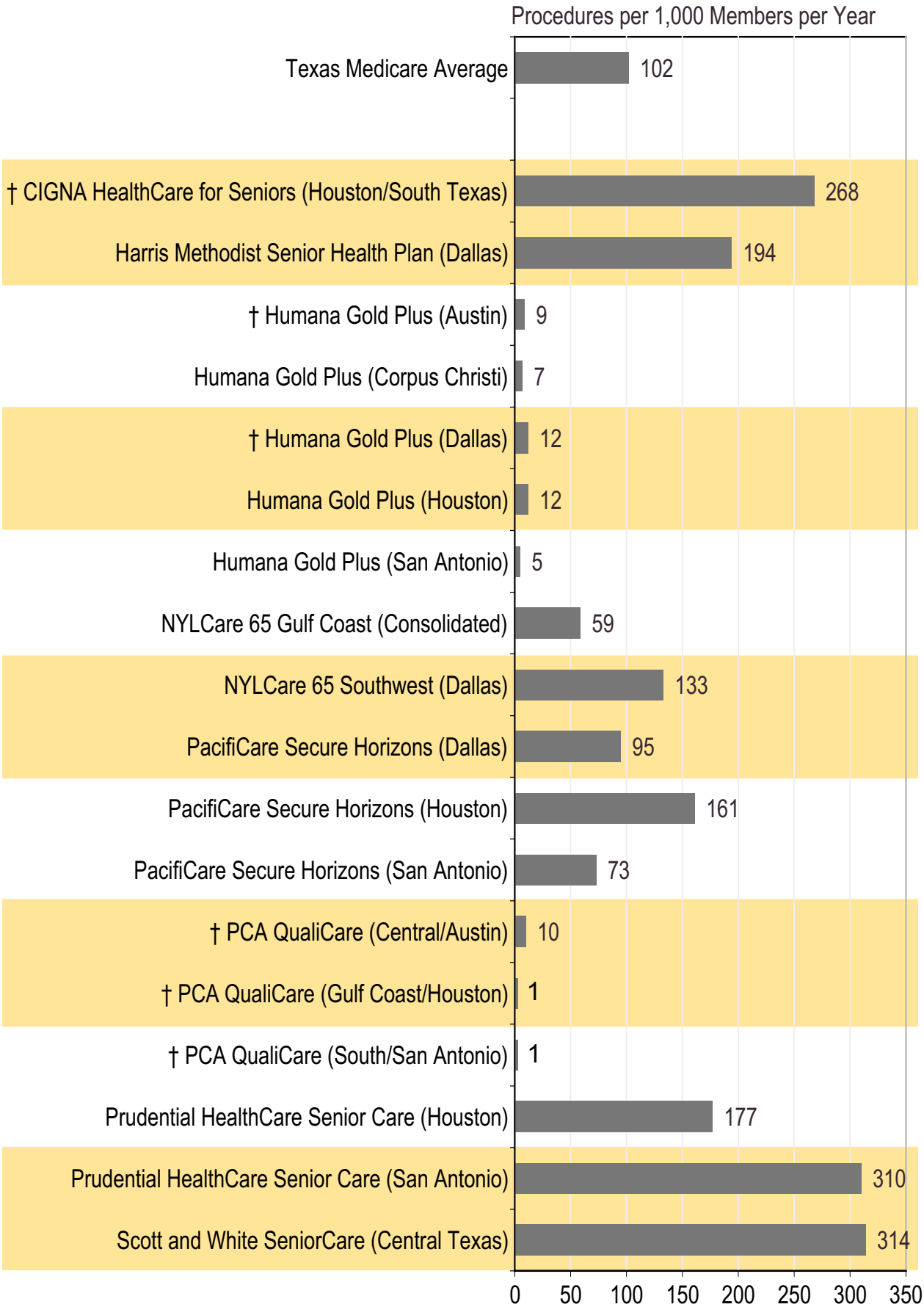
† These HMOs no longer participate in Medicare.

Ambulatory Care - Emergency Room Visits



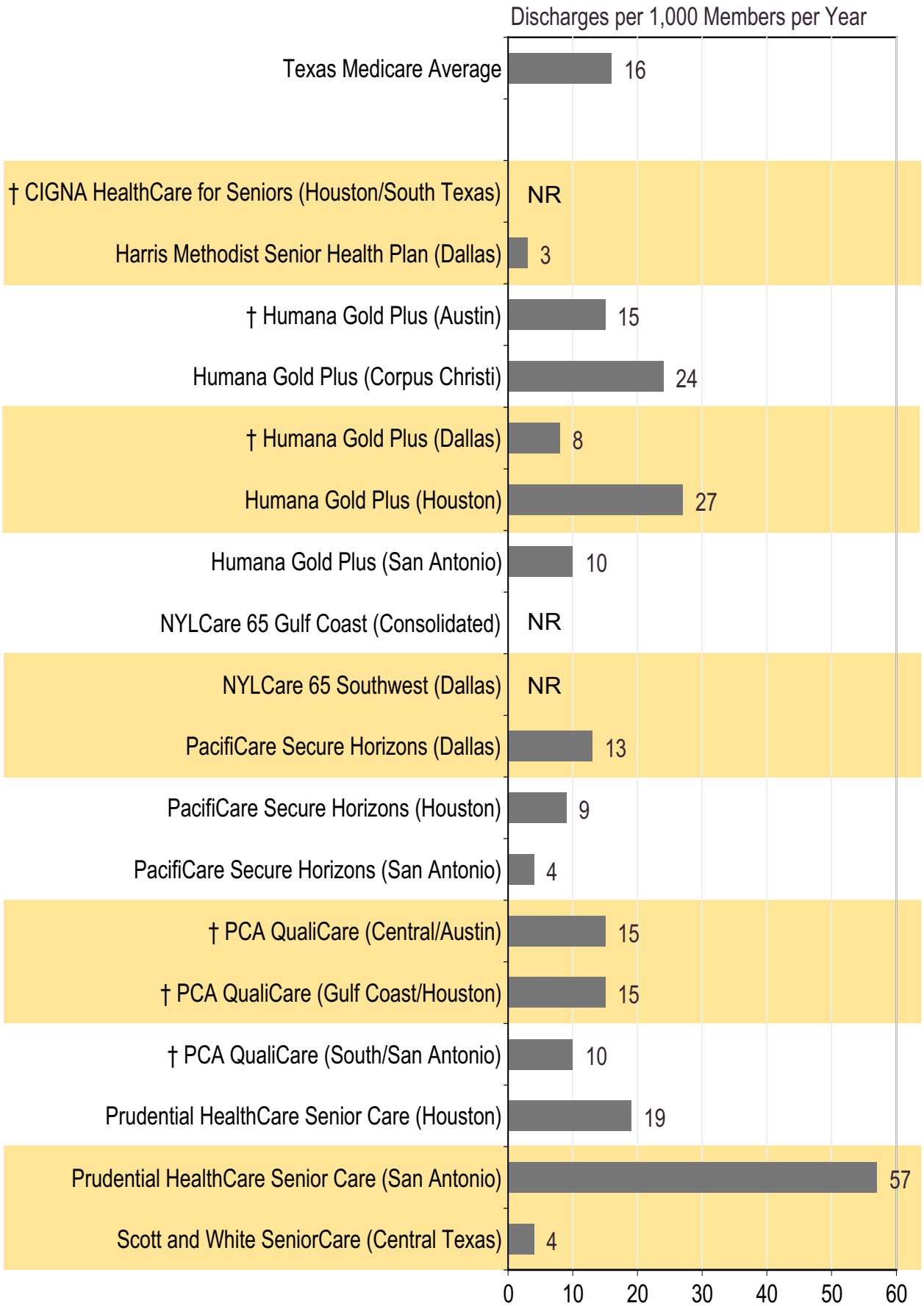
† These HMOs no longer participate in Medicare.

Ambulatory Care - Ambulatory Surgery/Procedures



† These HMOs no longer participate in Medicare.

Observation Room Stays



† These HMOs no longer participate in Medicare.

NR Failed to submit the required data or data not certified by NCQA licensed auditor.

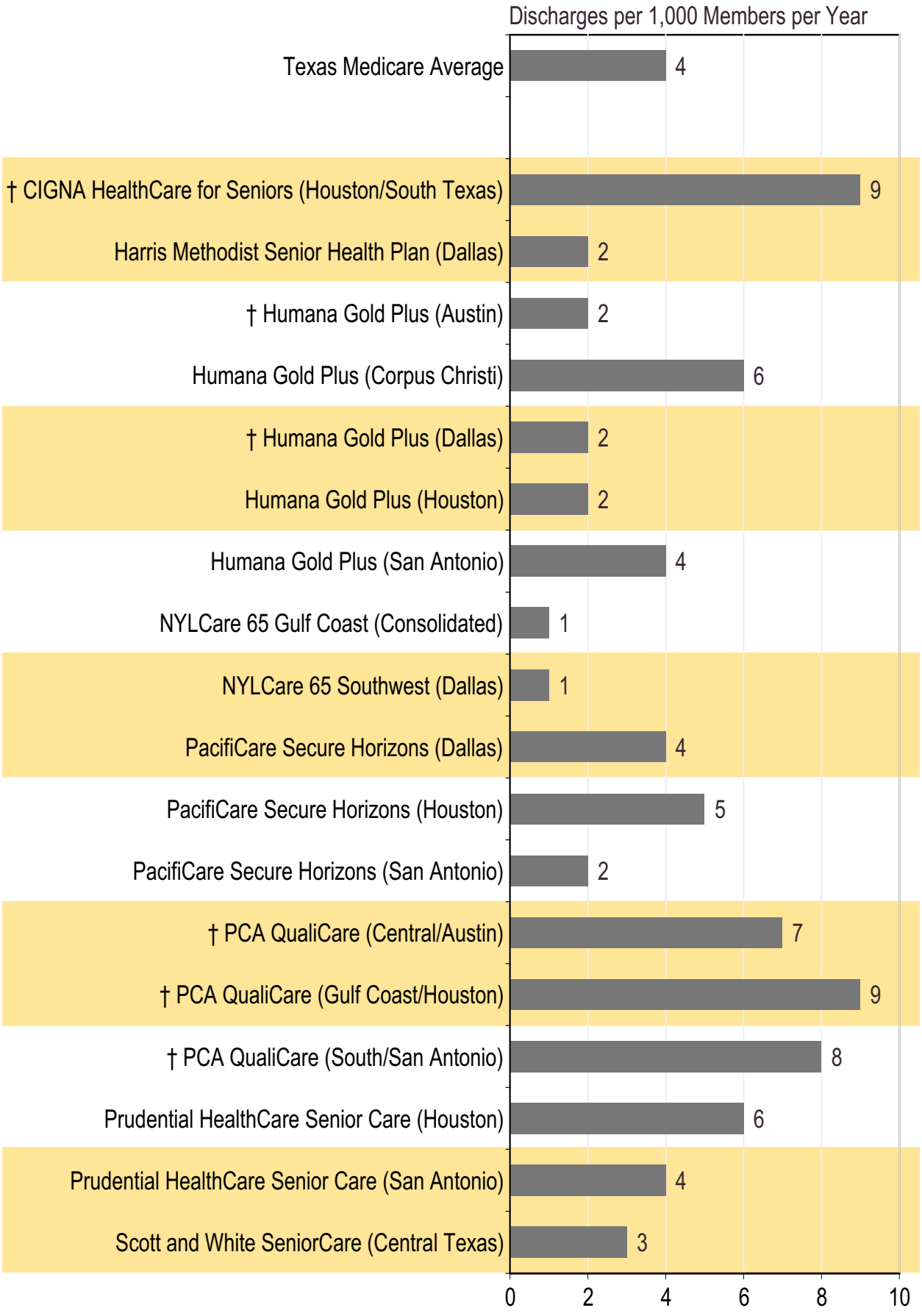
Mental Health Utilization

Definition: The number and average length of stay of hospitalizations for mental health disorders.

Almost 20% of older adults experience some mental disorders that are not part of the normal aging process. Hospitalizations for mental health disorders include anxiety disorders dementia, and depression. Untreated mental illness can lead to increased general medical expenses.

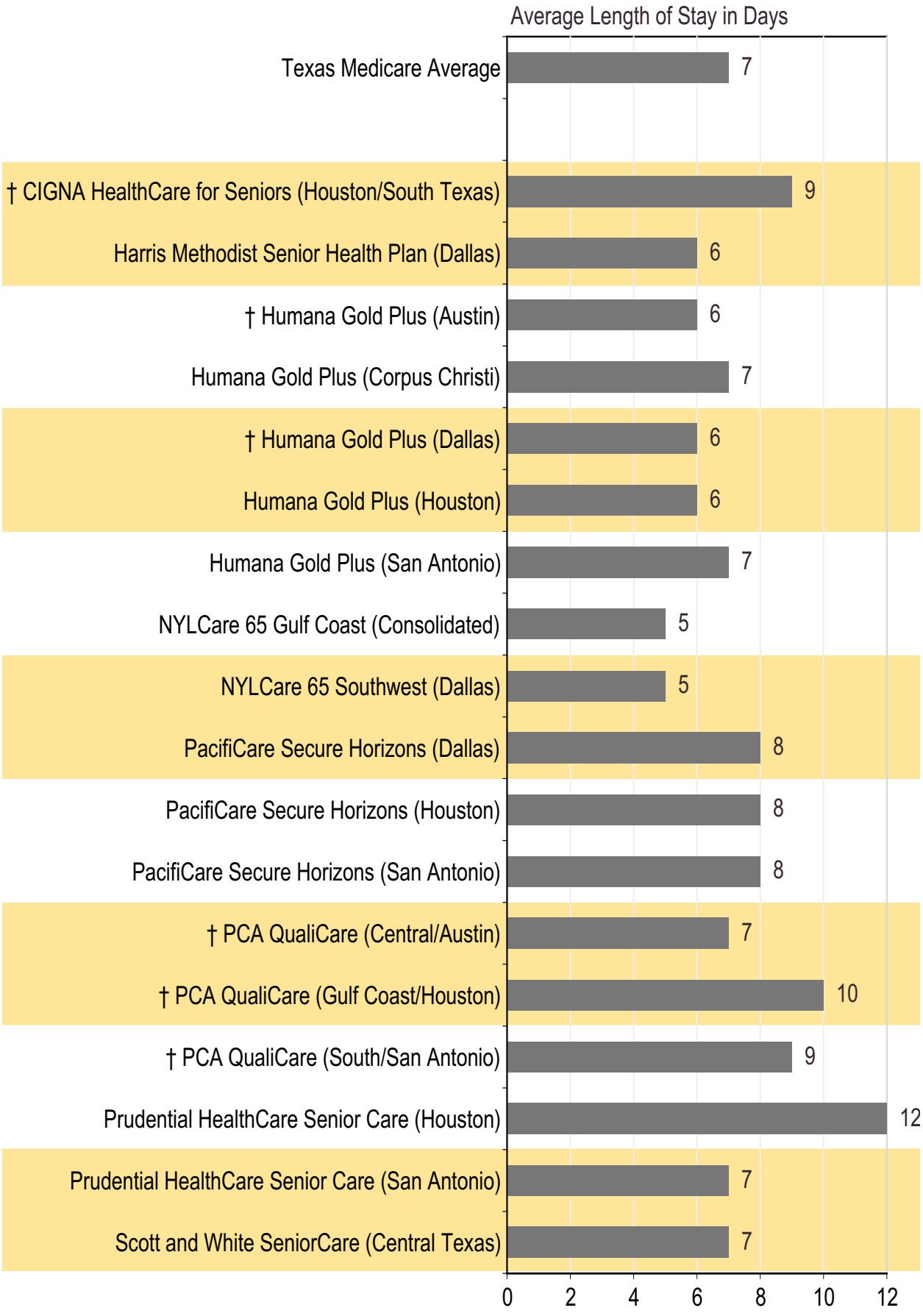
The graphs on the next two pages show the number of hospitalizations per 1,000 members and the average length of a hospital stay for mental health disorders in each Medicare HMO.

Mental Health Utilization



† These HMOs no longer participate in Medicare.

Mental Health Utilization



† These HMOs no longer participate in Medicare.

Practitioner Turnover

Definition: The percentage of primary care physicians affiliated with the health plan as of December 31, 1997 who were NOT affiliated with the plan as of December 31, 1998.

A primary care physician is usually a family doctor or internist who provides your regular and basic health care. Most people like to see the same provider over time. Developing a good relationship with your provider can increase the effectiveness of the care you receive. In managed care plans, your primary care physician (PCP) arranges your health care. The PCP refers you to a specialist when you need one.

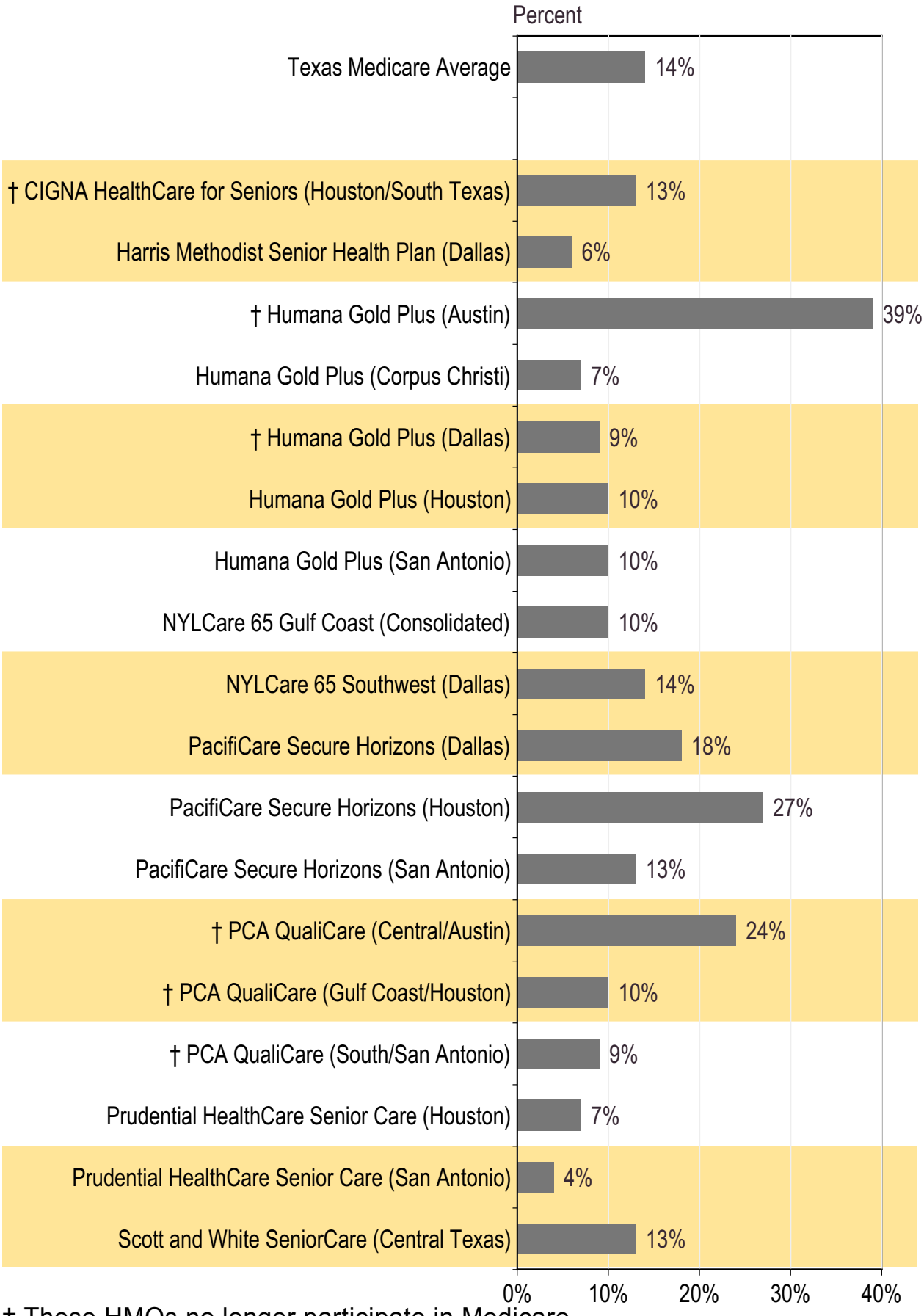
Providers may end their affiliation with the health plan for many reasons and some provider turnover is normal due to physician's retiring or relocating their practices. Some providers may end their affiliation with the health plan because of poor management and some health plans may drop providers because they are not following the plan's standard of care.

The graph on the next page shows the percentage of primary care physicians in each Medicare HMO in Texas who left the health plan during 1998.

Texas Medicare Average	
1997	*
1998	14%

* Value not available for 1997.

Practitioner Turnover



† These HMOs no longer participate in Medicare.

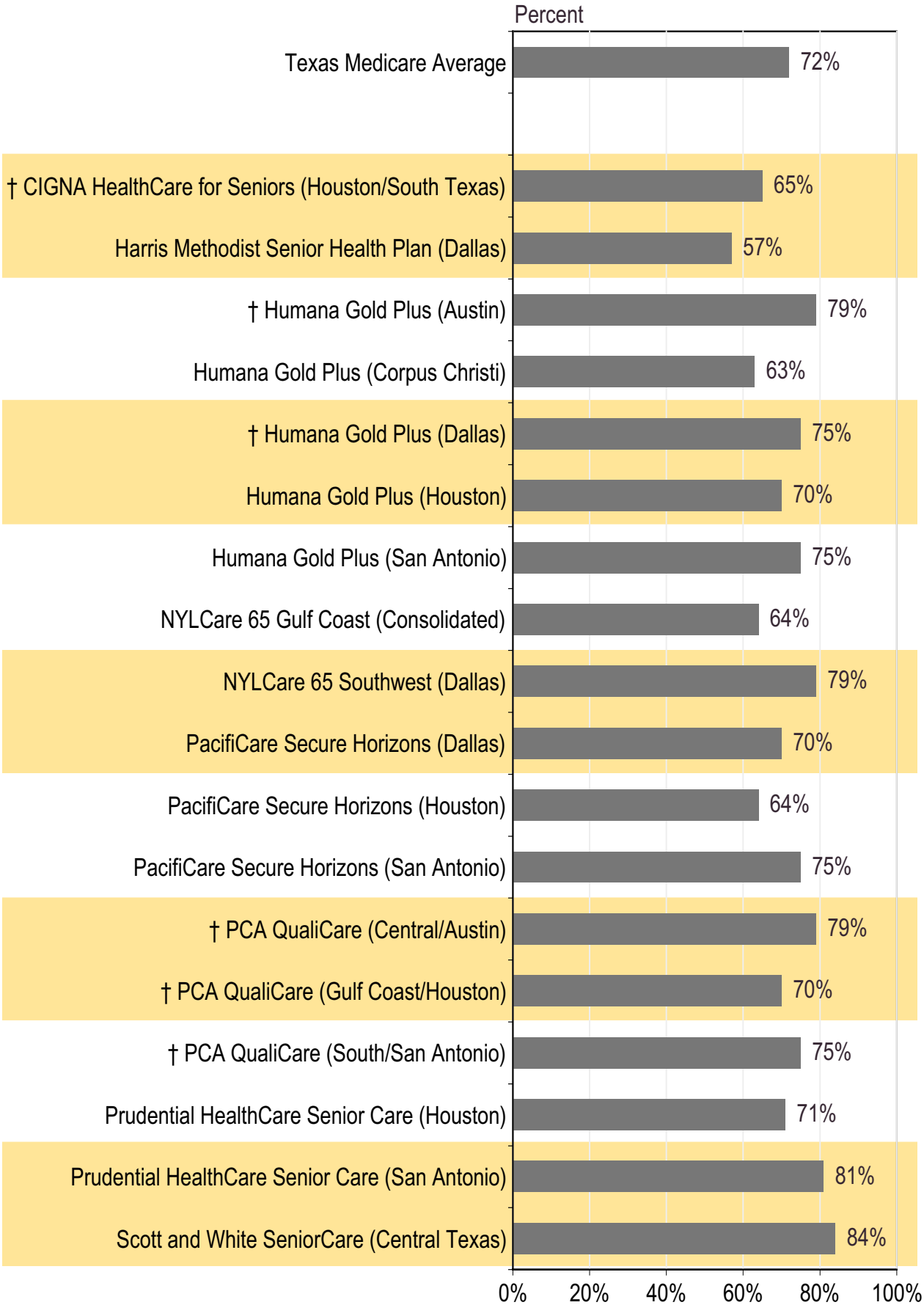
Board Certification - Primary Care Physicians/Other Physician Specialist

Definition: The percentage of primary care physicians and other physician specialists in each Medicare HMO who are board certified.

Board certification provides information on the credentials of the physicians who belong to the plan. If physicians are board certified, it means they have completed residency training and a certification program in their field of practice. The percentage of board certified physicians in each plan does not directly measure the quality of every doctor in the plan. It provides basic information about the qualifications of the plan's physicians.

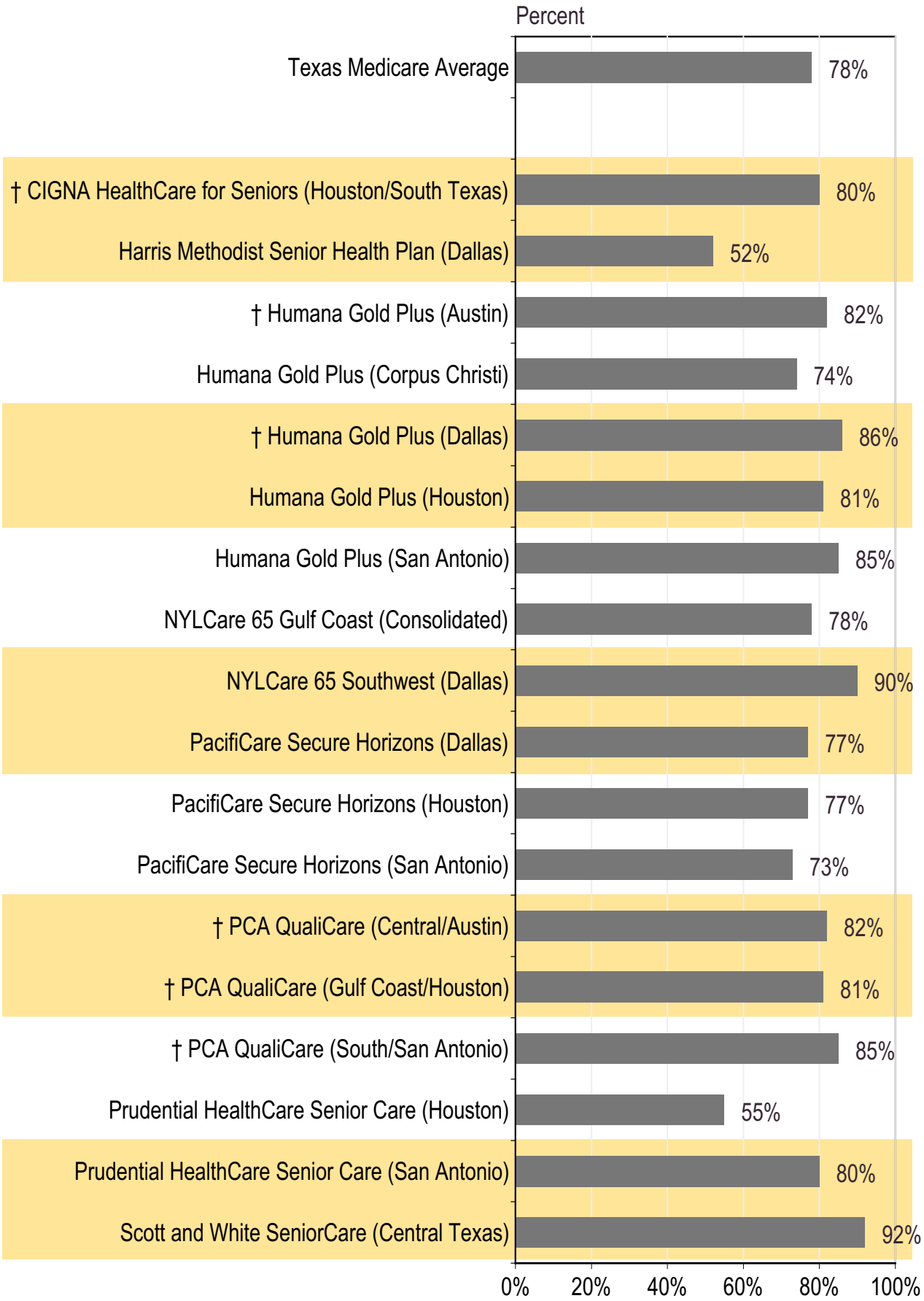
The graphs on the next two pages show the percentage of primary care physicians in each Medicare HMO who are board certified and the percentage of other physician specialists in each Medicare HMO who are board certified.

Board Certification - Primary Care Physicians



† These HMOs no longer participate in Medicare.

Board Certification - All Other Specialists



† These HMOs no longer participate in Medicare.

Indicators of Financial Stability*

Definition: The total revenues, expenses, and profits or losses that an individual health plan incurred during calendar year 1998.

Many HMOs in Texas and across the country have reported substantial operating losses since 1998. While these losses may appear alarming, consumers should know that HMOs are required by law to set aside adequate reserves to cover such losses.

HMOs licensed in Texas are regulated by the Texas Department of Insurance (TDI) and are subject to stringent financial operating and reporting requirements. HMOs are required by law to file detailed quarterly and annual financial statements that allow TDI to monitor the financial condition of each HMO. To avoid duplicative reporting requirements, THCIC obtained certain financial data from TDI for inclusion in this report. For more detailed information on all HMOs, you may wish to access the TDI website at *www.tdi.state.tx.us/company/hmo*.

The table on the next page provides the following information:

Revenues

Total Revenue: includes all revenue collected by the HMO, including premiums.

After Tax Net Income (Loss): the amount of income left in 1998 after all expenses and taxes are subtracted from revenue received in 1998. Losses are enclosed in parenthesis.

Expenses

Total Expenses: all expenses paid by the HMO, including medical services and supplies and all administrative costs.

Medical/Hospital Expense Ratio: the percentage of total expenses that an HMO pays for all medical and hospital services provided for its enrollees.

Administrative Expense Ratio: the percentage of total expenses that an HMO pays for all administrative and overhead costs such as salaries for management staff, marketing, rent and utilities.

* Narrative provided by the Texas Department of Insurance.

Indicators of Financial Stability*
REVENUES

Plan Name	Total Revenue in Dollars	After Tax Net Income (Loss) in Dollars
† CIGNA HealthCare for Seniors (Houston/South Texas)	$362,806,066	($6,432,211)
Harris Methodist Senior Health Plan (Dallas)	$592,703,059	($99,092,379)
† Humana Gold Plus (Austin)	$38,923,831	$4,824,391
Humana Gold Plus (Corpus Christi)	$78,540,764	$3,290,786
† Humana Gold Plus (Dallas)	$56,798,091	($4,159,271)
Humana Gold Plus (Houston)	$117,410,763	($14,288,651)
Humana Gold Plus (San Antonio)	$181,067,268	$193,946
NYLCare 65 Gulf Coast, Inc. (Consolidated)	$819,778,199	($16,467,665)
NYLCare 65 Southwest, Inc. (Dallas)	$423,951,165	$185,325
PacifiCare Secure Horizons (Dallas)	$144,814,481	($5,335,387)
PacifiCare Secure Horizons (Houston)	$173,816,192	$4,114,137
PacifiCare Secure Horizons (San Antonio)	$241,664,433	$12,169,901
† PCA QualiCare (Central/Austin)	$282,554,702	($676,582)
† PCA QualiCare (Gulf Coast/Houston)	$85,468,000	($476,314)
† PCA QualiCare (South/San Antonio)	$47,676,000	$808,150
Prudential HealthCare Senior Care (Houston)	$328,817,934	($1,724,327)
Prudential HealthCare Senior Care (San Antonio)	$114,470,903	($5,975,684)
Scott and White SeniorCare (Central Texas)	$225,263,221	$499,998

*Source: Texas Department of Insurance.
†-These HMOs no longer participate in Medicare.

Indicators of Financial Stability*
EXPENSES

Plan Name	Total Expenses in Dollars	Medical/Hosp. Expense Ratio	Admin. Expense Ratio
† CIGNA HealthCare for Seniors (Houston/South Texas)	$372,724,437	89.3%	10.7%
Harris Methodist Senior Health Plan (Dallas)	$691,795,438	83.6%	16.4%
† Humana Gold Plus (Austin)	$31,817,978	94.2%	5.8%
Humana Gold Plus (Corpus Christi)	$73,693,761	89.3%	10.7%
† Humana Gold Plus (Dallas)	$62,924,288	80.1%	19.9%
Humana Gold Plus (Houston)	$138,456,539	89.0%	11.0%
Humana Gold Plus (San Antonio)	$180,781,604	83.4%	16.6%
NYLCare 65 Gulf Coast, Inc. (Consolidated)	$845,113,864	87.6%	12.4%
NYLCare 65 Southwest, Inc. (Dallas)	$423,665,840	86.2%	13.8%
PacifiCare Secure Horizons (Dallas)	$152,665,130	85.2%	14.8%
PacifiCare Secure Horizons (Houston)	$167,765,990	87.1%	12.9%
PacifiCare Secure Horizons (San Antonio)	$223,767,520	88.9%	11.1%
† PCA QualiCare (Central/Austin)	$284,326,596	90.7%	9.3%
† PCA QualiCare (Gulf Coast/Houston)	$86,701,000	92.9%	7.1%
† PCA QualiCare (South/San Antonio)	$45,584,000	92.0%	8.0%
Prudential HealthCare Senior Care (Houston)	$330,542,261	84.3%	15.7%
Prudential HealthCare Senior Care (San Antonio)	$120,446,587	82.0%	18.0%
Scott and White SeniorCare (Central Texas)	$224,763,223	90.0%	10.0%

*Source: Texas Department of Insurance.
†-These HMOs no longer participate in Medicare.

Practitioner Compensation*

HMOs use a variety of financial arrangements to compensate providers who participate or belong to their health plan. In recent years, consumers and providers have expressed concern that some methods of financial compensation may persuade providers to limit medically necessary care.

To address these concerns, the Texas Legislature instructed the Texas Department of Insurance to adopt what is now known as "Patient Protection Rules". These rules specifically prohibit Texas licensed HMOs from using any financial incentives that act as an inducement to limit medically necessary services. However, these rules do not prohibit HMOs from establishing certain practice guidelines which doctors are expected to perform.

The table on the next page reports the percentage of providers that are paid according to the arrangement described below:

Fee for Service: the doctor or provider is paid for each service based on a contractual payment schedule between the provider and the HMO.

Capitation: the HMO pays the Primary Care Physician (or in some cases a physician group or clinic) a set monthly payment for every HMO member who selects that doctor as his/her Primary Care Physician. The fee is paid every month, regardless of whether the member is treated by the doctor

* Narrative provided by the Texas Department of Insurance.

Practitioner Compensation

Plan Name	Fee for Service	Capitation
† CIGNA HealthCare for Seniors (Houston/South Texas)	90%	10%
Harris Methodist Senior Health Plan (Dallas)	NR	NR
† Humana Gold Plus (Austin)	19%	81%
Humana Gold Plus (Corpus Christi)	27%	74%
† Humana Gold Plus (Dallas)	50%	50%
Humana Gold Plus (Houston)	11%	89%
Humana Gold Plus (San Antonio)	89%	11%
NYLCare 65 Gulf Coast (Consolidated)	NR	NR
NYLCare 65 Southwest (Dallas)	1%	99%
PacifiCare Secure Horizons (Dallas)	0%	100%
PacifiCare Secure Horizons (Houston)	0%	100%
PacifiCare Secure Horizons (San Antonio)	2%	98%
† PCA QualiCare (Central/Austin)	7%	93%
† PCA QualiCare (Gulf Coast/Houston)	11%	89%
† PCA QualiCare (South/San Antonio)	89%	11%
Prudential HealthCare Senior Care (Houston)	24%	76%
Prudential HealthCare Senior Care (San Antonio)	71%	29%
Scott and White SeniorCare (Central Texas)	NR	NR

†- These plans no longer participate in Medicare.
NR - Failed to submit the required data or data not certified by NCQA licensed auditor.

Total Enrollment

Definition: The percentage of each plan's members enrolled in Medicare, Medicare, or commercial insurance.

Generally speaking, there are three product lines offered by Texas HMOs: commercial, Medicare, and Medicaid. While this report only includes HEDIS® HMO performance data on Medicare members, the following page shows what proportion of the HMO's total business is represented by each product line. Medicare members are enrolled through a contract between the Health Care Financing Administration (HCFA) and the health plan. Medicaid members are enrolled through a contract between the state Medicaid agency (Texas Department of Health) and the health plan. Commercial members may be enrolled through an employer group policy or through an individual policy.

The table on the next page shows the percentage of each plans members enrolled in Medicare, Medicaid, or with Commercial insurance.

Total Enrollment

Plan Name	Total Enrollment Percent		
	Medicare	Commercial	Medicaid
† CIGNA HealthCare for Seniors (Houston/South Texas)	2%	98%	0%
Harris Methodist Senior Health Plan (Dallas)	7%	56%	37%
† Humana Gold Plus (Austin)	8%	91%	0%
Humana Gold Plus (Corpus Christi)	43%	57%	0%
† Humana Gold Plus (Dallas)	61%	39%	0%
Humana Gold Plus (Houston)	56%	44%	0%
Humana Gold Plus (San Antonio)	29%	71%	0%
NYLCare 65 Gulf Coast (Consolidated)	11%	89%	0%
NYLCare 65 Southwest (Dallas)	17%	83%	0%
PacifiCare Secure Horizons (Dallas)	28%	72%	0%
PacifiCare Secure Horizons (Houston)	32%	68%	0%
PacifiCare Secure Horizons (San Antonio)	37%	63%	0%
† PCA QualiCare (Central/Austin)	2%	82%	16%
† PCA QualiCare (Gulf Coast/Houston)	22%	78%	0%
† PCA QualiCare (South/San Antonio)	12%	43%	44%
Prudential HealthCare Senior Care (Houston)	3%	97%	0%
Prudential HealthCare Senior Care (San Antonio)	3%	97%	0%
Scott and White SeniorCare (Central Texas)	12%	88%	0%

†-These HMOs no longer participate in Medicare.

Enrollment by Payer

Definition: The percentage of each health plan's Medicare enrollment by gender and age group.

Membership data by gender and age may help explain the differences in the types of care and the total volume of services a health plan provides.

The following tables show the percentage of males and females by four age groups 0 - 64, 65 - 74, 75 - 84 and 85 +.

Enrollment by Payer - Males

percent of total plan enrollment by specific age categories

Plan Name	Age group 0-64	Age group 65-74	Age group 75-84	Age group 85+	Total Male
† CIGNA HealthCare for Seniors (Houston/South Texas)	8%	30%	9%	1%	49%
Harris Methodist Senior Health Plan (Dallas)	3%	25%	11%	2%	42%
† Humana Gold Plus (Austin)	3%	26%	10%	2%	41%
Humana Gold Plus (Corpus Christi)	8%	27%	13%	2%	50%
† Humana Gold Plus (Dallas)	7%	25%	10%	2%	44%
Humana Gold Plus (Houston)	7%	25%	10%	2%	44%
Humana Gold Plus (San Antonio)	8%	24%	11%	2%	45%
NYLCare 65 Gulf Coast (Consolidated)	3%	30%	11%	2%	45%
NYLCare 65 Southwest (Dallas)	3%	29%	10%	1%	44%
PacifiCare Secure Horizons (Dallas)	4%	25%	10%	2%	41%
PacifiCare Secure Horizons (Houston)	4%	25%	11%	2%	43%
PacifiCare Secure Horizons (San Antonio)	3%	25%	14%	2%	44%
† PCA QualiCare (Central/Austin)	2%	30%	12%	2%	46%
† PCA QualiCare (Gulf Coast/Houston)	9%	26%	11%	2%	49%
† PCA QualiCare (South/San Antonio)	9%	24%	9%	2%	44%
Prudential HealthCare Senior Care (Houston)	4%	27%	10%	2%	43%
Prudential HealthCare Senior Care (San Antonio)	5%	24%	11%	2%	43%
Scott and White SeniorCare (Central Texas)	2%	23%	13%	3%	41%

†-These HMOs no longer participate in Medicare.

Enrollment by Payer - Females

percent of total plan enrollment by specific age categories

Plan Name	Age group 0-64	Age group 65-74	Age group 75-84	Age group 85+	Total Female
† CIGNA HealthCare for Seniors (Houston/South Texas)	5%	30%	13%	3%	51%
Harris Methodist Senior Health Plan (Dallas)	3%	31%	18%	5%	58%
† Humana Gold Plus (Austin)	3%	35%	17%	5%	59%
Humana Gold Plus (Corpus Christi)	3%	28%	15%	4%	50%
† Humana Gold Plus (Dallas)	7%	30%	15%	4%	56%
Humana Gold Plus (Houston)	5%	31%	15%	4%	56%
Humana Gold Plus (San Antonio)	5%	30%	16%	4%	55%
NYLCare 65 Gulf Coast (Consolidated)	2%	34%	15%	4%	55%
NYLCare 65 Southwest (Dallas)	3%	35%	15%	3%	56%
PacifiCare Secure Horizons (Dallas)	4%	33%	18%	5%	59%
PacifiCare Secure Horizons (Houston)	3%	31%	18%	5%	57%
PacifiCare Secure Horizons (San Antonio)	2%	31%	18%	5%	56%
† PCA QualiCare (Central/Austin)	3%	31%	15%	4%	54%
† PCA QualiCare (Gulf Coast/Houston)	5%	27%	15%	4%	51%
† PCA QualiCare (South/San Antonio)	5%	30%	15%	6%	56%
Prudential HealthCare Senior Care (Houston)	3%	34%	16%	4%	57%
Prudential HealthCare Senior Care (San Antonio)	4%	32%	16%	4%	57%
Scott and White SeniorCare (Central Texas)	2%	31%	21%	6%	59%

†-These HMOs no longer participate in Medicare.

Texas Medicare HMOs Available as of January 1, 2000

Plan Name	Phone Number
Harris Methodist Senior Health Plan (Dallas)	1-800-662-2417
Healthfirst HMO (Tyler)	1-800-303-5155
Humana Gold Plus (Corpus Christi)	1-800-336-6702
Humana Gold Plus (Houston)	1-800-336-6702
Humana Gold Plus (San Antonio)	1-800-336-6702
MSCH Choice 65 (Houston)	1-800-909-6724
MethodistCare 65 Plus (Houston, Southeast)	1-800-619-9080
NYLCare 65 Gulf Coast (Consolidated)	1-800-572-5080
NYLCare 65 Southwest (Dallas)	1-800-435-2113
PacifiCare Secure Horizons (Dallas)	1-800-933-1674
PacifiCare Secure Horizons (Houston)	1-800-933-1674
PacifiCare Secure Horizons (San Antonio)	1-800-933-1674
Presbyterian Secure Horizons (El Paso)	1-800-939-2420
Prudential Senior Care (Houston)	1-800-772-3496
Prudential Senior Care (San Antonio)	1-800-781-7952
Scott and White Senior Care (Central Texas)	1-800-321-7947
Seton Senior Care (Austin)	1-800-749-7404
Texas Health Golden Choice (Dallas/Houston)	1-888-293-6831